Who Will Be Uninsured After Health Insurance Reform?

Matthew Buettgens, Urban Institute
Mark A. Hall, Wake Forest University

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Summary

The Patient Protection and Affordable Care Act (ACA) will expand insurance coverage by about 30 million people. Although this still falls short of universal coverage, the number of uninsured people will be reduced by more than half. This brief analyzes the likely composition, state by state, of those who will remain uninsured. This information can assist states and communities in health policy planning on several fronts. Principally, knowing more about who will remain uninsured will assist safety net providers, organizations, and support systems to determine ongoing needs for uninsured access and the optimal structures for meeting those needs.

In this brief, we project the effects of the ACA as if it were fully implemented in 2011. Our simulation finds that:

- The ACA would reduce the number of nonelderly people without health insurance by 28 million, from 18.9 percent of the nonelderly to 8.7 percent. Of the 23 million who would still be uninsured under health reform in 2011, 40 percent would be eligible for Medicaid or the Children's Health Insurance Program (CHIP), but not enrolled. A further 22 percent would be undocumented immigrants.
- For nonelderly adults, 19 million would be uninsured in 2011 under the ACA. It is useful to divide them into five groups:
  - Thirty-seven percent would be eligible for Medicaid, but not enrolled. These are mostly singles without dependents and relatively young.
  - Twenty-five percent would be undocumented immigrants. More than half of these would have incomes below 138 percent of the federal poverty level, so their emergency care would be covered by Medicaid.
  - Sixteen percent would be exempt from the individual mandate because they would not have an affordable insurance option. These would generally be older with relatively low incomes.
  - Eight percent would be eligible for affordable subsidized coverage in the health benefit exchanges. These would be mostly younger singles without dependents.
  - The remaining 15 percent of uninsured adults would likely be subject to the mandate, having an affordable private insurance option despite not qualifying for a subsidy. These have relatively high incomes and are mostly in families with dependents.

This composition would vary considerably among states, according to their economic and demographic characteristics and other factors, such as their pre-reform Medicaid eligibility criteria. For example, the uninsured rate among the nonelderly would vary regionally from 4.6 percent in New England to 11.4 percent in the West South Central region. Massachusetts would have the lowest rate (1.1 percent) and Texas the highest (12.8 percent).

Introduction

The Patient Protection and Affordable Care Act (ACA) will expand insurance coverage by about 30 million people. Although this still falls short of universal coverage, the number of uninsured people will be reduced by more than half. Safety net providers and programs, therefore, will still face the challenge of substantial numbers of uninsured who cannot afford a full range of needed services.

Even more than the number of uninsured, the *composition* of the uninsured will change substantially under the ACA, and accordingly, their reasons for being uninsured. Beginning in 2014, most Americans will be required to have health insurance coverage meeting certain minimum requirements and will be subject to financial penalties if they do not comply. Exemptions will also be granted if no affordable insurance coverage is

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available and for a variety of other specialized circumstances, such as people who are Native Americans, prisoners or have religious objections.[1] Medicaid eligibility will expand greatly for adults in many states, but little or not at all for children. Due to CHIP, their eligibility levels for public coverage are already much higher than for adults. Undocumented immigrants are not subject to the mandate, nor are they eligible for Medicaid or for any federal subsidies.

This brief analyzes this changing composition, state by state, of those who will remain uninsured. This information can assist states and communities in health policy planning on several fronts, such as planning for expected demand in the new insurance exchanges. Most importantly, knowing how many and what kinds of people will remain uninsured will assist safety net providers, organizations, and support systems to determine ongoing needs for those who cannot afford access and optimal structures for addressing those needs.

Methods

To estimate the effects of health reform and the individual mandate, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[2] HIPSM simulates the decisions of individuals and businesses in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.[3]

We simulate the main coverage provisions of the ACA as if they were fully implemented in 2011, and compare results to the HIPSM baseline results for 2011 without implementation of these reforms. This approach differs from that of the Congressional Budget Office or the CMS actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the pre-reform baseline and of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief providing a nationwide analysis of the ACA based in 2010.[4] This brief focuses on those who will remain uninsured, estimating the composition of the uninsured in each state.

The baseline HIPSM model calibrates behavior to agree with results from the empirical health economics literature. To simulate how behavior will change under the ACA's various provisions, we use information from Massachusetts since the only available empirical data are from that state, which has a similar law.[5] Our simulation of how behavior will change under the ACA includes three components:

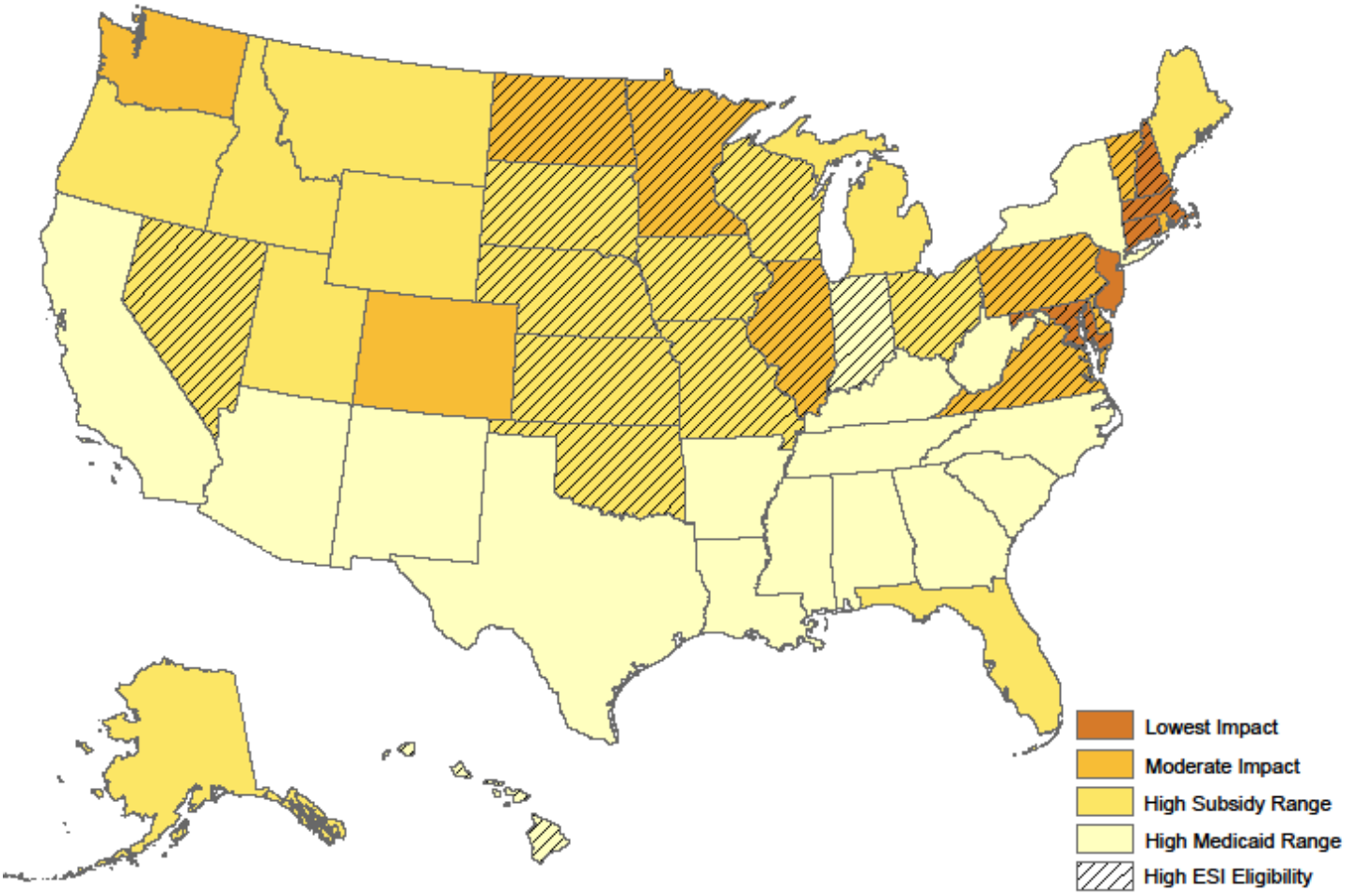
1. *The applicable financial penalty.* A computation of whether the penalty is applicable and the amount of the penalty as defined by the law.
2. *An additional "disutility" of not complying with the mandate.* The mandate is more than a dollar amount; it is a legal requirement. Desire to comply with the law, or at least to avoid enforcement and the stigma of noncompliance, can lead to behavioral responses much stronger than the amount of the nominal penalty would suggest. The mandate makes being uninsured less desirable—we operationalize this in the model by applying an additional "psychic" penalty to being uninsured.
3. *A relatively small "spillover" disutility of being uninsured on populations not bound by the mandate.* The mandate in Massachusetts was associated with an increase in coverage among those not bound by the mandate. We assume that this association was driven, in part, by a spillover effect of the mandate on those who were not bound by it who either mistakenly assumed they were or who reacted to a new social norm to have coverage. For those exempt from the mandate, the amount of additional disutility of being uninsured is far smaller than for those bound by the mandate.

To simulate state-level results, we made several enhancements to the model not reflected in earlier documentation. Two years of Current Population Survey (CPS) data (survey years 2010 and 2009) were pooled together to increase state sample size. State level results were suppressed when the number of unweighted observations fell below 130. Medical expenditures were adjusted to reflect state-level differences in health care pricing and utilization as measured in the National Health Expenditure Accounts.[6] Private health insurance premiums reflect state differences in health care pricing and utilization as well as the costs of those simulated to enroll in a particular type of insurance in a state.

Note that there are significant differences between insurance markets in the various states, particularly in the individual and small group markets. We did not model 51 different regulatory regimes with their various rules for premium rating, benefit package requirements, and so on. However, we take into account state-level variation in average premiums, which is driven in part by differences in the structure of insurance plans and other market factors in certain states. Following reform, market structures will be much more similar across states. Therefore, a model that accounts for baseline premiums is a reasonable approximation of the reform law's impact in each state.

Nevertheless, we emphasize that the estimates in this paper assume a uniform implementation of the ACA and that state-

Figure 1: Map of Income Clusters with ESI Eligibility



level estimates from the national version of HIPSM should not be considered a substitute for versions tailored to answering technical state policy questions and options. There are many important implementation decisions within a state's authority. Few decisions have been made; when they are, we will be able to incorporate them into future estimates. For now, there is value in comparing the effects of a consistent policy across states.

Undocumented immigrants are an important category of the uninsured. We impute immigration status using a methodology based on the work of Jeffrey Passel.[7] The overall number of undocumented is consistent with his estimates. In this paper, we deal exclusively with uninsured, undocumented immigrants.

Using cluster analysis, we separate states into four groups that have proven useful in analyzing our results (Figure 1):

- *Lowest impact* states are those in which about half of nonelderly adults are at or above 400 percent of the federal poverty level (FPL).[8] These states have a significantly lower share of the nonelderly eligible for Medicaid and exchange subsidies, so the ACA would be expected to have a somewhat lower impact.
- *Moderate impact* states have about 40 percent of nonelderly adults at or above 400 percent of the FPL and 30 to 40 percent between 138 and 400 percent of the FPL.
- *High subsidy impact* states have more nonelderly adults between 138 and 400 percent of the FPL than in either of the other two categories and have less than a third below 138 percent of the FPL. Thus, they have a particularly large population that exchange subsidies could potentially affect.
- Finally, *high Medicaid impact* states have about a third of nonelderly adults below 138 percent of the FPL, a higher proportion than the other groups. These also generally have a larger-than-average share in the 138 to 400 percent range.

Also, we identify states as having *low or high employer-sponsored insurance (ESI) eligibility* depending on whether less than 60 percent of nonelderly adults are eligible for ESI, that is, are potential policyholders. Those ineligible for ESI are either not in the workforce or hold jobs—particularly

part-time jobs—which would not have ESI as a benefit even if other workers in the firm were offered ESI. Figure 1 overlays income and ESI eligibility groups. An interesting pattern emerges. High ESI-eligibility states generally occur either in a cluster of low and moderate impact states along the Eastern seaboard, or in a cluster of moderate impact and high subsidy impact states in the Midwest.

Results

The Uninsured With and Without Health Reform

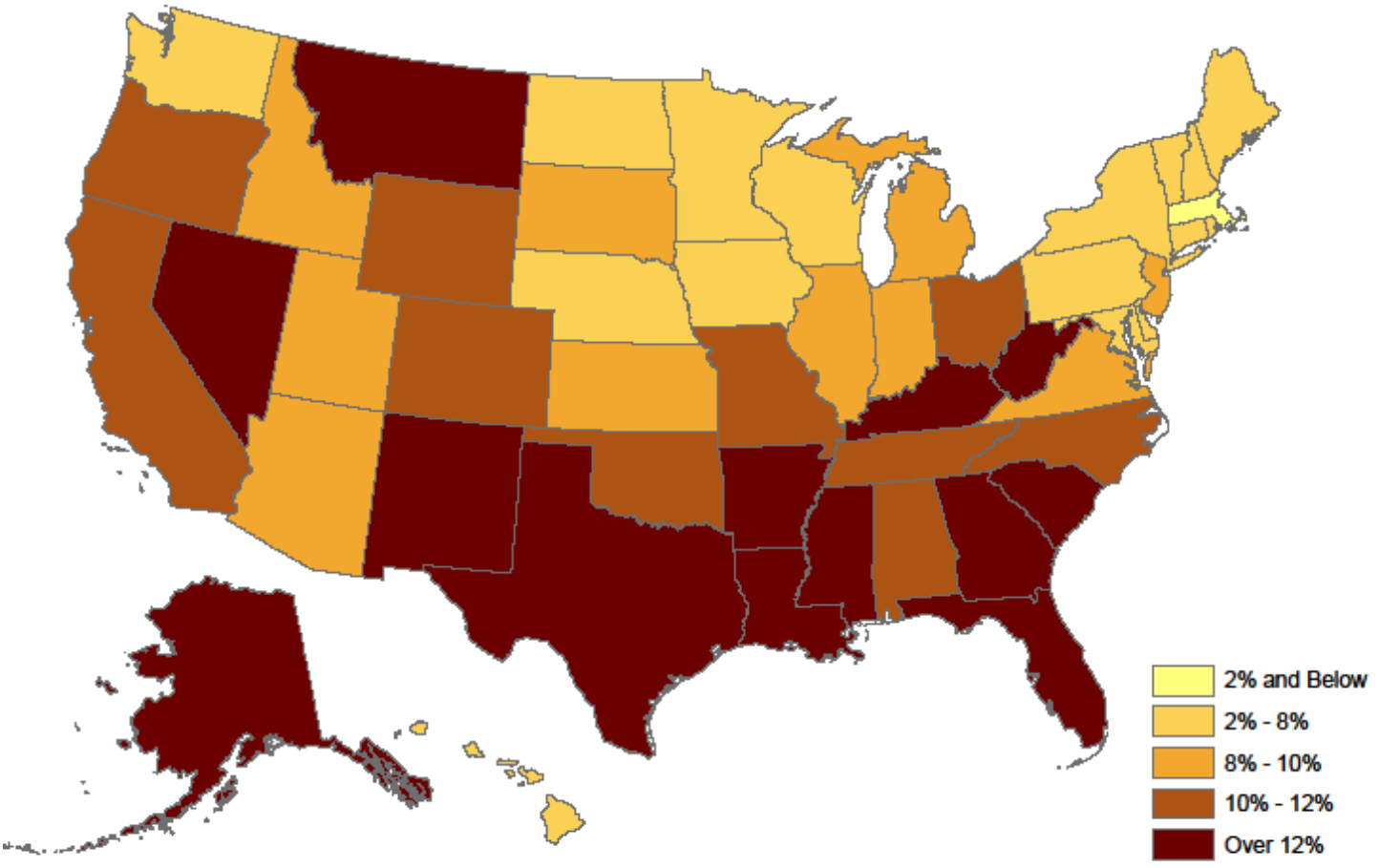
We begin with an overview of the uninsured without health reform (Table 1). Four regions—New England, the Middle Atlantic, East North Central and West North Central—all have uninsured rates for the nonelderly significantly below the national average of 18.9 percent. New England has the lowest rate, 8.9 percent. The remaining five regions all have uninsured rates near or above the national average. The West South Central region has the highest rate, 27.1 percent.

In most states, 80 to 90 percent of the current uninsured are adults. This reflects the higher level of coverage available to children through the Medicaid and CHIP programs. The state with the lowest threshold for children is North Dakota at 160 percent of the FPL, and most states have thresholds for children between 200 and 300 percent of the FPL. In contrast, eligibility thresholds for adult parents are very often less than 100 percent of the FPL and few states have any eligibility for nondisabled adults who are not parents.

In Table 1, we also estimate those who would be left uninsured under the ACA if fully implemented in 2011. Nationally, the uninsured rate drops from 18.9 to 8.7 percent. The smallest decline (1.1 percent) is in Massachusetts, which had by far the lowest uninsured rate to begin with. More generally, the four regions with uninsured rates below the national average would see smaller decreases in their uninsured rates. These are generally in the Northeast and Midwest, along with Washington and Hawaii (Figure 2). The states with the largest decreases would be New Mexico and Texas (16.0 and 16.9 percent, respectively). The states in which health reform would have the greatest impact on insurance coverage are concentrated in the South and West, along with Alaska.

A large majority of the uninsured would still be adults, but the share would be lower than without reform (79.7 percent versus 84 percent). This is because the Medicaid expansion would give far more adults than children new eligibility,[9] reflecting that current eligibility levels for adults are much lower than for children.[10]

Figure 2: Percentage Point Decline in the Uninsurance Rate Due to Reform



In Table 2, we show how the income distribution of the uninsured would vary by state under the ACA. Nationally, 51.2 percent would have incomes below 138 percent of the FPL, 34.5 percent between 138 and 400 percent of the FPL, and 13.8 percent above 400 percent of the FPL. New England shows a significantly different distribution from the other regions: only 39.8 percent below 138 percent, 36.7 percent between 138 and 400 percent, and 23.3 percent above 400 percent of the FPL. This region has the lowest overall uninsured rate before health reform; these states already covered low-income people at a relatively high rate.

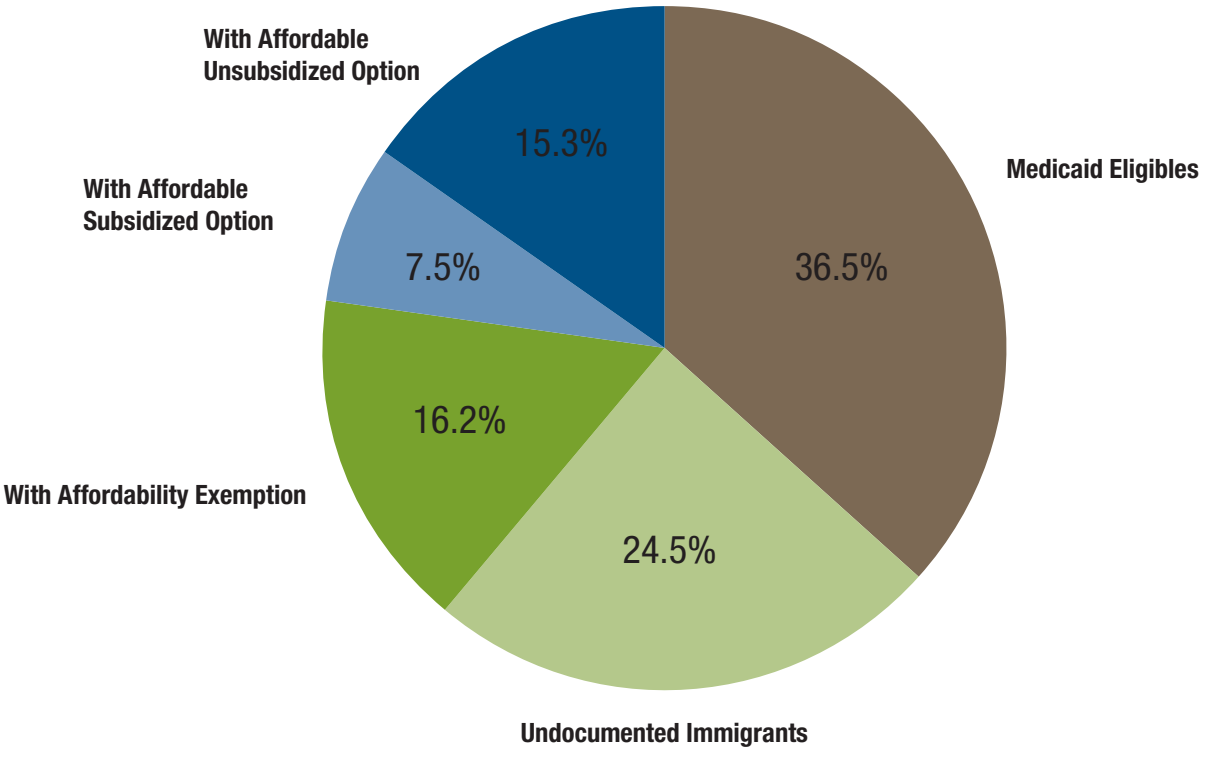
Nationally, 40 percent of the uninsured under the ACA would be eligible for Medicaid or CHIP but not enrolled, while an additional 22.2 percent would be undocumented immigrants (Table 3). Undocumented immigrants are banned from coverage in the health benefit exchanges and are ineligible for Medicaid. There is considerable regional variation in the composition of the nonelderly uninsured. In East South Central states, nearly half would be eligible for Medicaid or CHIP, and only 13.8 percent would be undocumented immigrants. In contrast, 36.2 percent of the uninsured in the Pacific region would be Medicaid/CHIP eligible, and 29.2 percent would be undocumented. Not surprisingly, California, Texas and Florida have high shares of undocumented immigrants among the nonelderly uninsured. New York shows a pattern similar to the East South Central region. Among income clusters, the lowest impact states (those with higher population incomes) have a significantly smaller share of Medicaid/CHIP eligibles, and high Medicaid impact states (populations with lower incomes) have a smaller share who are legal residents and not eligible for Medicaid or CHIP. High ESI states have a larger share who are legal residents and ineligible for Medicaid/CHIP.

Nonelderly Adults Uninsured Under the ACA

The rest of this brief focuses on nonelderly uninsured adults.[11] Table 4 divides their total number into five groups: those eligible for Medicaid; undocumented immigrants; legal residents who qualify for an affordability exemption from the individual mandate; legal residents who qualify for a subsidy, but not an affordability exemption; and other uninsured adults. Legal residents not eligible for Medicaid are eligible for subsidized coverage in the exchanges if their modified adjusted gross income (MAGI) is under 400 percent of the FPL, and they do not have an affordable ESI offer (defined as a single premium up to 9.5 percent of family income). An adult qualifies for an affordability exemption to the individual mandate if the individual premium he or she faces is more than 8 percent of family MAGI.[12] Some people qualifying for a subsidy are not subject to the mandate because the subsidy would not be sufficient to reduce premium cost below the mandate's threshold. Some of the "other uninsured persons" would also be exempt from the mandate for other reasons, such as religious objection or financial hardship, whose requirements remain to be specified in HHS regulations. The hardship exemption in particular could potentially apply to a large number of the uninsured, but this is impossible to estimate without knowing what guidelines HHS will use.

Nationally, 36.5 percent of the adult uninsured would be eligible for Medicaid (Figure 3).These individuals could be

Figure 3: Distribution of Nonelderly Uninsured Adults Under the ACA



enrolled through better outreach, and would potentially be covered by provisions of the ACA regarding presumptive eligibility determinations by hospitals.The next highest share of the adult uninsured, 24.5 percent, would be undocumented immigrants.The share of uninsured adults who are legal residents and do not have an affordable insurance option would be 16.2 percent.These would be exempt from the individual mandate. Seven and a half percent of uninsured adults would qualify for affordable subsidized coverage in the exchanges.The remainder of uninsured adults, 15.3 percent, would have an affordable private insurance option despite not qualifying for a subsidy. Most would thus be subject to the mandate.These last two segments constitute about two percent of the total nonelderly adult population.

Considerable variation will remain among states in the composition of the uninsured under the ACA. To illustrate differences in these distributions and the factors causing them, let us consider a few regions. First, New England is distinguished by having a very low share of uninsured Medicaid eligibles and a high share eligible for subsidies. This region has a relatively high income distribution, so a smaller share of nonelderly adults would be in the Medicaid eligibility range. Also, Medicaid eligibility and enrollment rates are relatively high for this region, while pre-reform uninsured rates are low. Per capita health care costs are higher than average, leading to higher premiums than other regions, and thus a better chance of qualifying for an affordability exemption.

The West South Central region has a high share of undocumented uninsured and low shares of uninsured adults eligible for Medicaid. This region has a relatively high share of undocumented immigrants among all nonelderly adults, very limited Medicaid eligibility for adults and relatively low per capita health care costs.

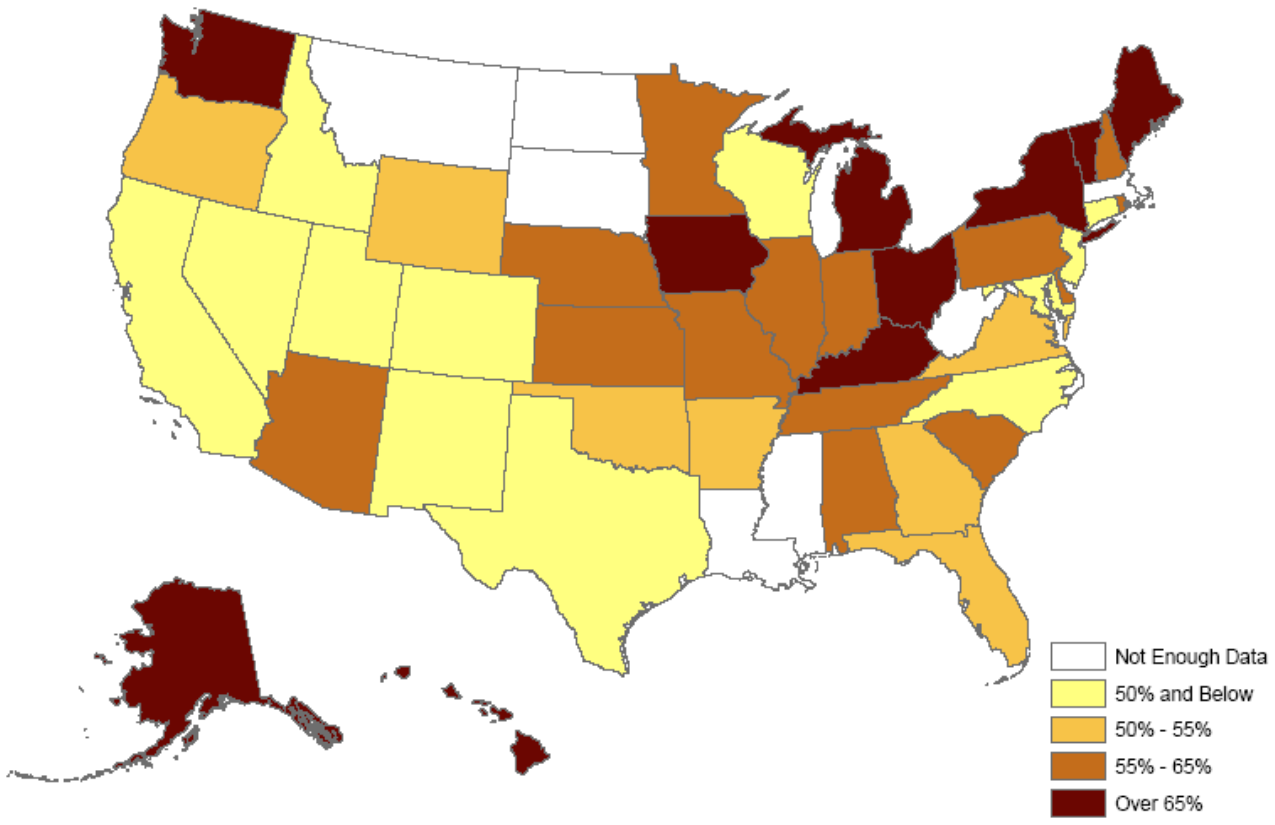
In Table 5, we report selected characteristics of these five groups of uninsured. Overall, almost half of the uninsured under the ACA would be singles with no dependents. The median age would be 37 and median MAGI would be 130 percent of the FPL.

Those eligible for Medicaid would be mostly singles without dependents and would be relatively young. Not surprisingly, their incomes would be very low.

Uninsured undocumented immigrants are generally low-income, with median household income at 130 percent of the FPL. More than half of these (53.5 percent) would have incomes below 138 percent of the FPL (Table 4). Since they would be otherwise eligible for Medicaid, their emergency services would be covered by Medicaid.[13] Most would be in families, and a high percentage would live in MSAs.

Half of those eligible for an affordability exemption would be singles without dependents and would be older (median age of 51), reflecting the ability of insurers to vary their premium rates under the ACA by three-fold based on age, for individual and small-group purchasers. Their incomes are moderately low (median of 250 percent of the FPL).

Figure 4: Percent of Uninsured Adults Eligible for Medicaid or Exchange Subsidies



Uninsured adults with affordable subsidies insurance options would be predominantly singles without children (61 percent) and somewhat younger (median age of 33), with moderately low incomes (median of 280 percent of the FPL). The remaining uninsured adults are overwhelmingly in families (71.2 percent) and have relatively high incomes (median of 490 percent of the FPL).

Across all these groups, the great majority of uninsured adults are located in metropolitan areas, but this geographic distribution varies widely across states, consistent with overall population densities.

In Table 6, we show how the share of uninsured adults who would be eligible for Medicaid or exchange subsidies would vary among states. We combine these two categories because those in both groups could benefit from outreach programs designed to encourage enrollment. (This also ensures that the sample size is large enough to present estimates for a majority of states.) Nationally, 55.2 percent would be eligible for one of the two programs. The East South Central region would have the largest percentage, 68.4 percent. This region includes the state with the highest percentage, Michigan (81.1 percent). This is a high subsidy impact state, a low ESI availability state, and has a high share of unenrolled Medicaid eligibles.

The two regions with the lowest share of uninsured adults eligible for Medicaid or subsidies are West South Central and Pacific, both at 49.5 percent. These regions include such prominent states as Texas and California, which have high shares of undocumented immigrants.

It is interesting to compare the map in Figure 3 with Figure 2. Generally, the states with the highest percentage point declines in the uninsured under health reform have the lowest shares of the remaining uninsured eligible for Medicaid or subsidies, and vice versa. In states that had low uninsured rates among low-income adults before reform—particularly those extending Medicaid eligibility to adults through waivers—the Medicaid expansion and exchange subsidies provide less new incentive for the uninsured to obtain coverage than in states currently without such affordable options for low-income adults. There are exceptions to this pattern, notably Kentucky and Alaska, which would see both large increases in coverage due to reform and a high share of the remaining uninsured eligible for Medicaid and exchange subsidies.

Conclusion

Health care reform will substantially change both the number and the composition of the uninsured. Less than 9 percent of the nonelderly would be uninsured if the ACA were fully effective in 2011, down from nearly 19 percent without reform. Two-fifths of the remaining uninsured would be eligible for Medicaid. A little more than a fifth would be undocumented immigrants. Since more than half of uninsured undocumented immigrants would have incomes below 138 percent of the FPL, Medicaid would cover their emergency care. Thus, Medicaid is relevant to more than half of those remaining uninsured (51.7 percent).

About a third of those remaining uninsured (34.5 percent) would be in the income range for exchange subsidies. Not all of these would be eligible for subsidies; some would have affordable offers of employer-sponsored insurance. The 13.8 percent of uninsured with incomes above 400 percent of the FPL would likely be subject to the individual mandate but would choose to remain uninsured.

Most of the 18.6 million uninsured nonelderly adults would be singles without dependents (57 percent). About 16 percent would not have an affordable insurance option, making them exempt from the individual mandate. These would be low-income and generally older. About 8 percent, mostly singles without dependents, would have access to affordable subsidized coverage in the health benefit exchanges. The remaining 15 percent, most of whom are in families, would have an affordable private insurance option despite not qualifying for a subsidy.

Safety net programs and providers that serve the uninsured can use these projections to adjust their policies and structures to best serve the needs of the many millions who remain uninsured even after the ACA is fully implemented.

Table 1. Total Nonelderly Uninsured With and Without Reform 2011

	Nonelderly Uninsured in Baseline				Total Uninsured Under Reform		
	Thousands	% of Population	% Adults	Thousands	% of Population	Pct point change from no reform	% Adults
New England:	**1,083**	**8.9%**	**86.1%**	**556**	**4.6%**	**-4.3%**	**79.4%**
Connecticut	397	13.1%	84.9%	197	6.5%	-6.6%	81.5%
Maine	147	13.2%	90.1%	66	5.9%	-7.3%	80.9%
Massachusetts	216	4.0%	83.0%	158	2.9%	-1.1%	72.2%
New Hampshire	136	11.9%	90.9%	50	4.3%	-7.6%	86.0%
Rhode Island	124	13.6%	84.1%	53	5.8%	-7.8%	78.0%
Vermont	62	11.7%	89.2%	32	6.1%	-5.6%	90.2%
Middle Atlantic:	**6,416**	**15.5%**	**86.0%**	**3,270**	**7.9%**	**-7.6%**	**83.4%**
Delaware	116	15.4%	80.9%	64	8.5%	-7.0%	77.9%
District of Columbia	67	12.2%	90.3%	35	6.5%	-5.8%	88.6%
Maryland	743	14.7%	88.1%	363	7.2%	-7.5%	83.4%
New Jersey	1,342	17.5%	83.5%	683	8.9%	-8.6%	80.5%
New York	2,814	16.5%	87.5%	1,599	9.4%	-7.1%	85.8%
Pennsylvania	1,334	12.9%	84.3%	526	5.1%	-7.8%	80.0%
East North Central:	**6,210**	**15.4%**	**87.0%**	**2,515**	**6.2%**	**-9.2%**	**82.0%**
Illinois	1,814	15.9%	87.2%	768	6.7%	-9.1%	84.6%
Indiana	870	15.9%	84.8%	326	6.0%	-10.0%	77.9%
Michigan	1,363	15.8%	89.7%	613	7.1%	-8.7%	84.4%
Ohio	1,591	16.0%	86.1%	562	5.7%	-10.3%	80.4%
Wisconsin	572	11.9%	85.7%	246	5.1%	-6.8%	76.5%
West North Central:	**2,340**	**13.4%**	**84.2%**	**1,037**	**6.0%**	**-7.5%**	**80.4%**
Iowa	296	11.3%	87.3%	171	6.6%	-4.8%	80.9%
Kansas	365	15.4%	81.4%	167	7.1%	-8.4%	76.1%
Minnesota	461	10.3%	83.9%	234	5.2%	-5.0%	84.2%
Missouri	803	15.6%	85.2%	284	5.5%	-10.1%	84.4%
Nebraska	229	14.7%	83.2%	106	6.8%	-7.9%	72.2%
North Dakota	75	13.6%	87.8%	33	6.1%	-7.5%	82.7%
South Dakota	110	15.9%	80.0%	41	5.9%	-10.0%	66.8%
South Atlantic:	**9,650**	**21.6%**	**83.3%**	**4,173**	**9.4%**	**-12.3%**	**79.1%**
Florida	3,979	26.0%	82.5%	1,741	11.4%	-14.6%	79.4%
Georgia	2,006	22.7%	83.2%	892	10.1%	-12.6%	79.8%
North Carolina	1,596	19.3%	84.2%	734	8.9%	-10.4%	79.3%
South Carolina	768	20.0%	82.3%	289	7.5%	-12.5%	75.0%
Virginia	1,033	14.9%	84.3%	439	6.3%	-8.6%	77.8%
West Virginia	268	18.0%	90.7%	77	5.2%	-12.8%	84.8%
East South Central:	**2,983**	**19.0%**	**86.5%**	**1,168**	**7.5%**	**-11.6%**	**80.4%**
Alabama	707	17.5%	89.8%	266	6.6%	-10.9%	84.7%
Kentucky	735	20.0%	85.7%	251	6.8%	-13.1%	73.3%
Mississippi	539	21.2%	80.1%	214	8.4%	-12.8%	72.8%
Tennessee	1,003	18.5%	88.3%	437	8.1%	-10.5%	85.5%
West South Central:	**8,747**	**27.1%**	**80.6%**	**3,664**	**11.4%**	**-15.8%**	**74.5%**
Arkansas	558	22.7%	86.1%	201	8.2%	-14.5%	83.3%
Louisiana	822	21.3%	86.7%	292	7.6%	-13.7%	80.2%
Oklahoma	608	19.5%	82.0%	260	8.3%	-11.1%	73.0%
Texas	6,758	29.7%	79.3%	2,911	12.8%	-16.9%	73.5%
Mountain:	**4,172**	**21.1%**	**80.0%**	**2,088**	**10.5%**	**-10.5%**	**75.5%**
Arizona	1,328	22.3%	78.9%	802	13.5%	-8.8%	76.6%
Colorado	829	18.4%	82.2%	372	8.2%	-10.1%	78.0%
Idaho	244	18.2%	80.4%	110	8.2%	-10.0%	68.3%
Montana	182	21.5%	84.1%	74	8.8%	-12.7%	79.7%
Nevada	557	23.7%	79.4%	274	11.7%	-12.0%	75.2%
New Mexico	515	28.0%	82.4%	220	12.0%	-16.0%	74.2%
Utah	433	17.3%	74.3%	201	8.0%	-9.3%	69.9%
Wyoming	84	17.7%	84.2%	35	7.3%	-10.4%	78.3%
Pacific:	**9,299**	**20.6%**	**85.3%**	**4,818**	**10.7%**	**-9.9%**	**82.0%**
Alaska	130	21.1%	83.6%	53	8.5%	-12.5%	79.4%
California	7,561	22.1%	85.0%	3,930	11.5%	-10.6%	81.9%
Hawaii	104	9.5%	85.6%	53	4.8%	-4.7%	77.4%
Oregon	683	20.4%	84.2%	303	9.0%	-11.3%	75.7%
Washington	821	13.9%	89.4%	480	8.2%	-5.8%	86.9%
Total U.S.A.	**50,900**	**18.9%**	**84.0%**	**23,289**	**8.7%**	**-10.3%**	**79.7%**

Source: Urban Institute analysis, HIPSM 2011.

Table 2. Composition of the Nonelderly Uninsured Under Reform, By Income

	Total (thousands)	Under 138% FPL		138% - 400% FPL		138% - 400% FPL	
		N	%	N	%	N	%
New England:	**556**	**221**	**39.8%**	**204**	**36.7%**	**131**	**23.5%**
Connecticut	197	85	42.9%	80	40.4%	33	16.6%
Maine	66	20	30.6%	32	48.4%	14	21.0%
Massachusetts	158	66	41.9%	38	24.1%	54	34.0%
New Hampshire	50	13	25.6%	22	45.0%	15	29.4%
Rhode Island	53	25	46.9%	20	37.1%	8	16.0%
Vermont	32	13	39.7%	12	37.4%	7	22.9%
Middle Atlantic:	**3,270**	**1,602**	**49.0%**	**1,115**	**34.1%**	**553**	**16.9%**
Delaware	64	38	59.6%	18	28.2%	8	12.2%
District of Columbia	35	17	48.4%	14	38.8%	5	12.8%
Maryland	363	163	44.9%	133	36.7%	67	18.4%
New Jersey	683	284	41.5%	273	40.0%	126	18.5%
New York	1,599	857	53.6%	486	30.4%	256	16.0%
Pennsylvania	526	243	46.2%	191	36.4%	92	17.4%
East North Central:	**2,515**	**1,337**	**53.2%**	**866**	**34.4%**	**312**	**12.4%**
Illinois	768	364	47.4%	302	39.3%	102	13.3%
Indiana	326	180	55.2%	117	36.0%	29	8.8%
Michigan	613	394	64.2%	150	24.4%	69	11.3%
Ohio	562	310	55.0%	195	34.7%	58	10.3%
Wisconsin	246	90	36.7%	102	41.4%	54	21.8%
West North Central:	**1,037**	**565**	**54.4%**	**322**	**31.1%**	**150**	**14.5%**
Iowa	171	105	61.2%	40	23.5%	26	15.3%
Kansas	167	97	57.9%	51	30.7%	19	11.4%
Minnesota	234	119	50.7%	73	31.3%	42	18.0%
Missouri	284	152	53.7%	96	33.8%	36	12.5%
Nebraska	106	53	50.2%	35	33.2%	18	16.6%
North Dakota	33	16	47.4%	12	37.1%	5	15.5%
South Dakota	41	23	55.4%	14	34.3%	4	10.3%
South Atlantic:	**4,173**	**2,146**	**51.4%**	**1,453**	**34.8%**	**574**	**13.7%**
Florida	1,741	854	49.1%	636	36.5%	251	14.4%
Georgia	892	516	57.9%	258	29.0%	117	13.1%
North Carolina	734	412	56.1%	254	34.5%	68	9.3%
South Carolina	289	148	51.3%	98	33.9%	43	14.8%
Virginia	439	181	41.3%	179	40.8%	78	17.9%
West Virginia	77	34	43.5%	28	36.6%	15	19.9%
East South Central:	**1,168**	**633**	**54.2%**	**414**	**35.5%**	**121**	**10.4%**
Alabama	266	153	57.6%	79	29.8%	33	12.6%
Kentucky	251	128	51.1%	105	42.0%	17	6.9%
Mississippi	214	105	49.0%	84	39.5%	25	11.5%
Tennessee	437	246	56.4%	145	33.2%	45	10.4%
West South Central:	**3,664**	**1,863**	**50.8%**	**1,343**	**36.7%**	**458**	**12.5%**
Arkansas	201	111	55.3%	63	31.5%	27	13.2%
Louisiana	292	156	53.4%	91	31.3%	45	15.3%
Oklahoma	260	112	43.0%	113	43.5%	35	13.5%
Texas	2,911	1,483	51.0%	1,076	37.0%	352	12.1%
Mountain:	**2,088**	**1,123**	**53.8%**	**680**	**32.6%**	**285**	**13.6%**
Arizona	802	511	63.8%	207	25.9%	83	10.4%
Colorado	372	171	46.0%	134	36.2%	66	17.8%
Idaho	110	43	38.8%	53	48.3%	14	12.8%
Montana	74	33	45.1%	30	40.4%	11	14.6%
Nevada	274	130	47.6%	119	43.3%	25	9.1%
New Mexico	220	129	58.4%	58	26.5%	33	15.1%
Utah	201	93	46.2%	65	32.1%	44	21.7%
Wyoming	35	13	37.7%	13	37.6%	9	24.7%
Pacific:	**4,818**	**2,553**	**53.0%**	**1,633**	**33.9%**	**632**	**13.1%**
Alaska	53	23	44.2%	21	40.4%	8	15.4%
California	3,930	2,118	53.9%	1,293	32.9%	519	13.2%
Hawaii	53	32	60.6%	16	29.4%	5	10.0%
Oregon	303	153	50.5%	101	33.4%	49	16.1%
Washington	480	227	47.3%	202	42.0%	51	10.7%
Total U.S.A.	**23,289**	**12,043**	**51.7%**	**8,030**	**34.5%**	**3,215**	**13.8%**

Source: Urban Institute analysis, HIPSM 2011.

Table 3. Composition of Nonelderly Uninsured Under the ACA, 2011

	Medicaid Eligible		Undocumented		Other	
	Thousands	% of Uninsured	Thousands	% of Uninsured	Thousands	% Of Uninsured
Regions:						
New England	181	32.6%	89	16.0%	286	51.4%
Middle Atlantic	1,399	42.8%	638	19.5%	1,233	37.7%
East North Central	1,199	47.7%	308	12.2%	1,007	40.1%
West North Central	476	45.9%	147	14.2%	414	40.0%
South Atlantic	1,590	38.1%	991	23.7%	1,592	38.1%
East South Central	561	48.1%	162	13.8%	445	38.1%
West South Central	1,352	36.9%	933	25.5%	1,379	37.6%
Mountain	823	39.4%	497	23.8%	768	36.8%
Pacific	1,744	36.2%	1,406	29.2%	1,668	34.6%
Largest States:						
California	1,399	35.6%	1,225	31.2%	1,305	33.2%
Texas	1,033	35.5%	820	28.2%	1,058	36.3%
New York	779	48.7%	231	14.4%	589	36.8%
Florida	608	34.9%	449	25.8%	684	39.3%
Illinois	309	40.3%	139	18.1%	319	41.6%
Income Cluster:						
Lowest Impact	467	32.2%	401	27.6%	583	40.2%
Moderate Impact	1,190	39.2%	559	18.4%	1,287	42.4%
High Subsidy Impact	2,187	41.2%	941	17.7%	2,180	41.1%
High Medicaid Impact	5,482	40.6%	3,269	24.2%	4,743	35.1%
Eligibility Cluster:						
High ESI	2,202	40.9%	890	16.5%	2,298	42.6%
Low ESI	7,123	39.8%	4,280	23.9%	6,495	36.3%
Total U.S.A.	**9,326**	**40.0%**	**5,170**	**22.2%**	**8,793**	**37.8%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 4. Distribution of Nonelderly Uninsured Adults Under the ACA, 2011

Population (thousands)	Total non-elderly adults	Total non-elderly adults uninsured		Medicaid eligibiles	Undocumented immigrants	With Affordability Exemption	With Affordable Subsidized Option	With Affordable Unsubsidized Option
		N	% of nonelderly	% of uninsured	% of uninsured	% of uninsured	% of uninsured	% of uninsured
Regions:								
New England	8,712.4	441.5	5.1%	28.7%	18.7%	24.5%	9.8%	18.2%
Middle Atlantic	29,607.4	2,727.1	9.2%	38.4%	21.5%	15.4%	8.5%	16.3%
East North Central	28,406.3	2,061.2	7.3%	46.1%	12.3%	19.2%	8.0%	14.4%
West North Central	12,227.0	834.1	6.8%	42.6%	14.9%	14.8%	9.0%	18.7%
South Atlantic	31,782.1	3,300.9	10.4%	34.0%	26.4%	16.4%	7.9%	15.4%
East South Central	11,131.0	938.4	8.4%	46.0%	15.5%	16.4%	6.7%	15.4%
West South Central	21,923.7	2,730.6	12.5%	32.5%	29.4%	15.7%	6.4%	16.0%
Mountain	13,605.6	1,575.7	11.6%	36.0%	26.8%	13.7%	6.8%	16.7%
Pacific	31,552.4	3,949.0	12.5%	32.4%	31.8%	15.7%	7.1%	13.1%
Largest States:								
California	23,774.0	3,220.1	13.5%	31.3%	34.3%	15.1%	6.3%	12.9%
Texas	15,304.0	2,138.8	14.0%	30.6%	32.4%	15.7%	6.6%	14.7%
New York	12,250.5	1,372.3	11.2%	45.3%	15.6%	16.8%	7.7%	14.6%
Florida	11,177.7	1,383.5	12.4%	30.9%	28.2%	19.8%	7.6%	13.6%
Illinois	8,070.7	649.8	8.1%	36.5%	18.5%	19.9%	9.9%	15.1%
Income Cluster:								
Lowest Impact	15,872.2	1,170.7	7.4%	26.9%	31.6%	17.7%	7.5%	16.3%
Moderate Impact	33,296.0	2,495.2	7.5%	35.5%	19.7%	17.0%	10.4%	17.4%
High Subsidy Impact	47,293.7	4,172.8	8.8%	38.6%	19.1%	18.5%	7.8%	16.0%
High Medicaid Impact	92,485.9	10,719.8	11.6%	36.9%	26.9%	14.9%	6.7%	14.5%
Eligibility Cluster:								
High ESI	63,230.1	4,307.4	6.8%	37.2%	18.0%	18.0%	9.1%	17.7%
Low ESI	125,700.0	14,251.2	11.3%	36.3%	26.4%	15.7%	7.1%	14.6%
Total U.S.A.	**188,947.8**	**18,558.5**	**9.8%**	**36.5%**	**24.5%**	**16.2%**	**7.5%**	**15.3%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.

Table 5. Characteristics of Nonelderly Adults Uninsured Under the ACA, 2011

	Percent singles with no dependents	Median age	Median family income*	Median FPL ratio	Percent Below 138% FPL	Percent in MSAs
Medicaid Eligibles	57.2%	32.0	$3,008.67	0.2	---	83.3%
Undocumented Immigrants	45.1%	35.0	$18,757.85	1.3	53.1%	93.4%
With Affordability Exemption	51.1%	51.0	$31,125.13	2.5	---	84.6%
With Affordable Subsidized Option	60.6%	33.0	$36,054.75	2.8	---	86.2%
With Affordable Unsubsidized Option	28.8%	43.0	$66,581.80	4.9	---	80.9%
Total U.S.A.	**49.2%**	**37.0**	**$20,335.08**	**1.3**	**50.8%**	**85.8%**

Source: Urban Institute analysis, HIPSM 2011.
Note: We simulate the provisions of the Affordable Care Act fully implemented in 2011.
* Total income of the health insurance unit

Table 6. Nonelderly Adults Uninsured Yet Eligible for Medicaid or Exchange Subsidies

	Total Uninsured (thousands)	Percent Eligible for Medicaid or Exchange Subsidies
New England:	**442**	**55.9%**
Connecticut	161	49.2%
Maine	53	65.7%
Massachusetts	*	*
New Hampshire	43	56.1%
Rhode Island	41	55.3%
Vermont	29	68.0%
Middle Atlantic:	**2,727**	**58.7%**
Delaware	50	57.6%
District of Columbia	31	54.3%
Maryland	303	47.8%
New Jersey	550	42.6%
New York	1,372	67.2%
Pennsylvania	421	60.2%
East North Central:	**2,061**	**68.4%**
Illinois	650	60.4%
Indiana	254	64.7%
Michigan	518	81.1%
Ohio	452	75.9%
Wisconsin	188	47.7%
West North Central:	**834**	**62.4%**
Iowa	138	67.2%
Kansas	127	56.2%
Minnesota	197	60.5%
Missouri	239	63.4%
Nebraska	77	60.0%
North Dakota	*	*
South Dakota	*	*
South Atlantic:	**3,301**	**53.1%**
Florida	1,383	53.0%
Georgia	711	54.8%
North Carolina	582	48.9%
South Carolina	217	56.3%
Virginia	341	52.5%
West Virginia	*	*
East South Central:	**938**	**63.3%**
Alabama	226	59.1%
Kentucky	184	66.4%
Mississippi	*	*
Tennessee	373	64.0%
West South Central:	**2,731**	**49.5%**
Arkansas	167	51.0%
Louisiana	*	*
Oklahoma	190	52.6%
Texas	2,139	47.6%
Mountain:	**1,576**	**51.2%**
Arizona	614	57.2%
Colorado	290	41.0%
Idaho	75	49.9%
Montana	*	*
Nevada	206	49.0%
New Mexico	163	49.5%
Utah	141	45.5%
Wyoming	27	53.3%
Pacific:	**3,949**	**49.5%**
Alaska	42	69.3%
California	3,220	46.8%
Hawaii	41	69.1%
Oregon	229	50.7%
Washington	417	66.3%
Total U.S.A.	**18,559**	**55.2%**

Source: Urban Institute analysis, HIPSM 2011.
* Estimates not deemed sufficiently reliable due to small sample size.

Notes

[1] Some of these miscellaneous exemptions cannot yet be modeled because their operation depends on regulations not yet issued. Also, we do not model short-term gaps in coverage, which also are exempt (if they are three months or less).

[2] For more about HIPSM and a list of recent research using it, see http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.urban.org/url.cfm?ID=411905.

[3] HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

[4] Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act," (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412267.

[5] We draw mainly from the results of the Massachusetts Health Insurance Survey, Sharon K. Long, Allison Cook, and Karen Stockley, "Access to Health Care in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey" (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=1001403.

[6] National Health Expenditure Accounts, CMS Office of the Actuary. https://www.cms.gov/NationalHealthExpendData/.

[7] Jeffery S. Passel and D'Vera Cohn, "Unauthorized Immigrant Population: National and State Trends, 2010," (Washington, DC: Pew Hispanic Center, February 2011) http://pewhispanic.org/reports/report.php?ReportID=133.

[8] For the distribution of MAGI by state, see Table 1 of Matthew Buettgens, John Holahan, and Caitlin Carroll, "Health Reform across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid" (Washington, DC: The Urban Institute, March 2011), http://www.rwjf.org/files/research/71952.pdf.

[9] Although all states have Medicaid/CHIP eligibility thresholds higher than 138 percent of the FPL, because the ACA uses a different definition of income, a small number of children would gain eligibility.

[10] This assumes that states maintain their existing Medicaid/CHIP levels for children, but that is by no means certain. Although the ACA's "maintenance-of-effort" provision requires continued Medicaid coverage for children until 2019, it does not provide the necessary funding. A forthcoming collaboration between the Urban Institute and Georgetown University's Center for Children and Families will examine this and other health reform issues affecting children.

[11] A forthcoming collaboration between the Urban Institute and Georgetown University's Center for Children and Families will examine health reform issues affecting children.

[12] According to the Joint Committee on Taxation's *Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as Amended, in Combination with the Patient Protection and Affordable Care Act* (JCX-18-10, March 21, 2010), if self-only coverage is affordable for a worker but family coverage is not, an uninsured employee would be subject to the penalty for nonenrollment, while the family members eligible for employer coverage through that employee would not be penalized. It is unclear at the present time whether those family members would then be eligible for subsidies for coverage purchased through the exchange. JCT's explanation of this provision highlighted the lack of statutory clarity. Their interpretation is not binding; the actual implementation will be specified in regulations. The JCT, however, is the most authoritative interpretation currently available, so we use it in our modeling.

[13] Hospital presumptive eligibility provisions in the ACA section 10203 may also benefit this group.

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About the Authors

Matthew Buettgens is a senior research methodologist of the Urban Institute's Health Policy Center. Mark A. Hall is the Fred D. and Elizabeth L. Turnage Professor of Law and Public Health at Wake Forest University. The authors wish to thank Caitlin Carroll and Jeremy Roth for excellent research assistance.

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